This is an amendment to 8.200.400 NMAC, Sections 8, 10 and 14, effective 1/1/2022.

8.200.400.8 [~~RESERVED~~] MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.200.400.8 NMAC - Rp, 8.200.400.8 NMAC, 1/1/2019; A, 1/1/2022]

8.200.400.10 BASIS FOR DEFINING GROUP - MEDICAID CATEGORIES:

A. Except where noted, the HSD income support division (ISD) determines eligibility in the categories listed below:

(1) other adult (Category 100);

(2) parent caretaker (Category 200);

(3) pregnant women (Category 300);

(4) pregnancy-related services (Category 301);

(5) loss of parent caretaker due to earnings from employment or due to spousal support (Categories 027 and 028);

(6) newborn (Category 031);

(7) children under age 19 (Categories 400, 401, 402, 403, 420, and 421);

(8) children, youth, and families department medicaid (Categories 017, 037, 046, 04, 066, and 086); and

(9) family planning (Category 029).

B. Medicare savings program (MSP): MSP assists an eligible recipient with the cost of medicare.

(1) Medicare is the federal government program that provides health care coverage for individuals 65 or older; or under 65 who have a disability. Individuals under 65 who have a disability are subject to a waiting period of 24 months from the approval date of social security disability insurance (SSDI) benefits before they receive medicare coverage. Coverage under medicare is provided in four parts.

(a) Part A hospital coverage is usually free to beneficiaries when medicare taxes are paid while working.

(b) Part B medical coverage requires monthly premiums, co-insurance and deductibles to be paid by the beneficiary.

(c) Part C advantage plan allows a beneficiary to choose to receive all medicare health care services through a managed care organization.

(d) Part D provides prescription drug coverage.

(2) The following MSP programs can assist an eligible recipient with the cost of medicare.

(a) Qualified medicare beneficiaries (QMB) - Categories 041 and 044: QMB covers low income medicare beneficiaries who have or are conditionally eligible for medicare Part A. QMB benefits are limited to the following:

(i) cost for the monthly medicare Part B premium;

(ii) cost of medicare deductibles and coinsurance; and

(iii) cost for the monthly medicare Part A premium (for those enrolling conditionally).

(b) Specified low-income medicare beneficiaries (SLIMB) - Category 045: SLIMB medicaid covers low-income medicare beneficiaries who have medicare Part A. SLIMB is limited to the payment of the medicare Part B premium.

(c) Qualified individuals 1 (QI1s) - Category 042: QI1 medicaid covers low-income medicare beneficiaries who have medicare Part A. QI1 is limited to the payment of the medicare part B premium.

(d) Qualified disabled working individuals (QDI) - Category 050: QDI medicaid covers low income individuals who lose entitlement to free medicare Part A hospital coverage due to gainful employment. QDI is limited to the payment of the monthly Part A hospital premium.

(e) Medicare Part D prescription drug coverage - low income subsidy (LIS) - Category 048: LIS provides individuals enrolled in medicare Part D with a subsidy that helps pay for the cost of Part D prescription premiums, deductibles and co-payments. An eligible recipient receiving medicaid through

QMB, SLMB or QI1 is automatically deemed eligible for LIS and need not apply. Other low-income medicare beneficiaries must meet an income and resource test and submit an application to determine if they qualify for LIS.

C. Supplemental security income (SSI) related medicaid:

(1) SSI - Categories 001, 003 and 004: Medicaid for individuals who are eligible for SSI. Eligibility for SSI is determined by the social security administration (SSA). This program provides cash assistance and medicaid for an eligible recipient who is:

(a) aged (Category 001);

(b) blind (Category 003); or

(c) disabled (Category 004).

(2) SSI medicaid extension - Categories 001, 003 and 004: MAD provides coverage for certain groups of applicants or eligible recipients who have received supplemental security income (SSI) benefits and who have lost the SSI benefits for specified reasons listed below and pursuant to 8.201.400 NMAC:

(a) the pickle amendment and 503 lead;

(b) early widow(er);

(c) disabled widow(er) and a disabled surviving divorced spouse;

(d) child insurance benefits, including disabled adult children (DAC);

(e) nonpayment SSI status (E01);

(f) revolving SSI payment status "ping-pongs"; and

(g) certain individuals who become ineligible for SSI cash benefits and, therefore, may receive up to two months of extended medicaid benefits while they apply for another MAD category of eligibility.

(3) Working disabled individuals (WDI) and medicare wait period - Category 074: There are two eligibility types:

(a) a disabled individual who is employed; or

(b) a disabled individual who has lost SSI medicaid due to receipt of SSDI and the individual does not yet qualify for medicare.

D. Long term care medicaid:

(1) medicaid for individuals who meet a nursing facility (NF) level of care (LOC), intermediate care facilities for the intellectually disabled (ICF-ID) LOC, or acute care in a hospital. SSI income methodology is used to determine eligibility. An eligible recipient must meet the SSA definition of aged (Category 081); blind (Category 083); or disabled (Category 084).

(2) Institutional care (IC) medicaid - Categories 081, 083 and 084: IC covers certain inpatient, comprehensive and institutional and nursing facility benefits.

(3) Program of all-inclusive care for the elderly (PACE) - Categories 081, 083 and 084: PACE uses an interdisciplinary team of health professionals to provide dual medicaid/medicare enrollees with coordinated care in a community setting. The PACE program is a unique three-way partnership between the federal government, the state, and the PACE organization. The PACE program is limited to specific geographic service area(s). Eligibility may be subject to a wait list for the following:

(a) the aged (Category 081);

(b) the blind (Category 083); or

(c) the disabled (Category 084).

(4) Home and community-based 1915 (c) waiver services (HCBS) - Categories 090, 091, 092, 093, 094, 095 and 096: A 1915(c) waiver allows for the provision of long term care services in home and community based settings. These programs serve a variety of targeted populations, such as people with mental illnesses, intellectual disabilities, or physical disabilities. Eligibility may be subject to a wait list.

(a) There are two HCBS delivery models:

(i) traditional agency delivery where HCBS are delivered and managed by a MAD enrolled agency; or

(ii) mi via self-directed where an eligible recipient, or his or her representative, has decision-making authority over certain services and takes direct responsibility to manage the eligible mi via recipient's services with the assistance of a system of available supports; self-direction of services allows an eligible mi via recipient to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

(b) HCBS waiver programs include:

(i) elderly (Category 091), blind (Category 093) and disabled (Category 094);

(ii) medically fragile (Category 095);
(iii) developmental disabilities (Category 096); and
(iv) self-directed model for Categories 090, 091, 093, 094, 095, 096 and 092).

E. Emergency medical services for [~~aliens (EMSA)~~] non-citizens (EMSNC): [~~EMSA~~] EMSNC medicaid covers certain non-citizens who either are undocumented or who do not meet the qualifying non-citizen criteria specified in 8.200.410 NMAC. Non-citizens must meet all eligibility criteria for one of the medicaid categories noted in 8.285.400 NMAC, except for citizenship or qualified non-citizen status. Medicaid eligibility for and coverage of services under [~~EMSA~~] EMSNC are limited to the payment of emergency services from a medicaid provider.

F. Refugee medical assistance (RMA) - Categories 049 and 059: RMA offers health coverage to certain low income refugees during the first eight months from their date of entry to the United States (U.S.) when they do not qualify for other medicaid categories of eligibility. A RMA eligible refugee recipient has access to a benefit package that parallels the full coverage medicaid benefit package. RMA is funded through a grant under Title IV of the Immigration and Nationality Act (INA). A RMA applicant who exceeds the RMA income standards may "spend-down" below the RMA income standards for Category 059 by subtracting incurred medical expenses after arrival into the U.S.

G. Breast and cervical cancer (BCC) - Category 052: BCC medicaid provides coverage to an eligible uninsured woman, under the age of 65 who has been screened and diagnosed by the department of health (DOH) as having breast or cervical cancer to include pre-cancerous conditions. The screening criteria are set forth in the centers for disease control and prevention's national breast and cervical cancer early detection program (NBCCEDP). Eligibility is determined using DOH notification and without a separate medicaid application or determination of eligibility.

[8.200.400.10 NMAC - Rp, 8.200.400.10 NMAC, 1/1/2019; A, 1/1/2022]

8.200.400.14 RETROACTIVE MEDICAID:

A. HSD must make eligibility for medicaid effective no later than the first or up to the third month before the month of application if the individual:

(1) Requested coverage for months prior to the application month;
(2) received medicaid services, at any time during that period, of a type covered under the plan and;
(3) would have been eligible for medicaid at the time he or she received the services, if he or she had applied (or an authorized representative has applied for him or her) regardless of whether the individual is alive when application for medicaid is made.

B. Eligibility for medicaid is effective on the first day of the month if an individual was eligible at any time during that month.

C. Eligibility for each retroactive month is determined separately. Retroactive medicaid must be requested within 180 days of the date of the medicaid application.

D. Retroactive medicaid is allowed for up to three months prior to the application month for the following medicaid categories:

(1) other adults (COE 100);
(2) parent caretaker (COE 200);
(3) pregnant women (COE 300);
(4) pregnancy-related services (COE 301);
(5) children under age 19 (COEs 400, 401, 402, 403, 420, and 421);
(6) family planning (COE 029);
(7) children, youth and families department (CYFD COEs 017, 037, 046, 047, 066, and 086);
(8) supplemental security income (SSI COEs 001, 003, and 004);
(9) SSI (COEs 001, 003, and 004, e.g. 503s, disabled adult children, ping pongs, and early widowers);
(10) working disabled individuals (COE 074);
(11) breast and cervical cancer (BCC COE 052);
(12) specified low income beneficiaries (SLIMB COE 045);
(13) qualified individuals (QI1 COE 042);
(14) qualified disabled working individuals (COE 050);
(15) refugees (COE 049); and

(16) institutional care medicaid (COEs 081, 083, and 084) excluding the program for all-inclusive care for the elderly (PACE).

E. The following categories do not have retroactive medicaid:

(1) emergency medical services for [~~aliens~~] non-citizens ([~~EMSA~~] EMSNC COE 085). [~~EMSA~~] EMSNC provides coverage for emergency services, which may be provided prior to the application month, but is not considered retroactive medicaid. Eligibility is determined in accordance with 8.285.400, 8.285.500, and 8.285.600 NMAC;

(2) home and community based-services waivers (COEs 091, 093, 094, 095, and 096);

(3) PACE (COEs 081, 083, and 084);

(4) qualified medicare beneficiaries (COEs 041 and 044); and

(5) transitional medicaid (COEs 027 and 028).

F. Newborns (COE 031) are deemed to have applied and been found eligible for the newborn category of eligibility from birth through the month of the child's first birthday. This applies in instances where the labor and delivery services were furnished prior to the date of the application and covered by medicaid based on the mother applying for up to three months of retroactive eligibility.

[8.200.400.14 NMAC - Rp, 8.200.400.14 NMAC, 1/1/2019; A, 2/1/2020; A, 1/1/2022]